(15)

No. 90-97

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner

v.

NATIONAL LABOR RELATIONS BOARD, et al.

Respondents

On Petition For A Writ Of Certiorari To The United States Court of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF THE VIRGINIA HOSPITAL ASSOCIATION

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I. INTEREST OF THE AMICUS CURIAE

The Virginia Hospital Association submits its brief as *amicus curiae* in support of the Petitioner, the American Hospital Association.[1] The Virginia Hospital Association ("VHA") is a private non-profit membership organization which serves as an advocate for the Virginia hospital industry providing leadership, representation and services to its member hospitals. The VHA strives to serve its members by developing and promoting programs that will enhance the

[1] All parties to this proceeding have given their written consent for the filing of this *amicus curiae* brief. The consent letters are set forth in the Appendix to this brief. (App., *infra*, 1a-4a).

ability of its members to provide comprehensive, efficient, quality health care to all Virginians.

The VHA has ninety-five acute care hospital members representing all the acute care hospitals in the State of Virginia. The VHA has a diverse membership with hospitals of varying sizes and missions. Some of its hospital members are located in metropolitan areas such as Richmond or Northern Virginia locales surrounding Washington, D.C. Many other acute care hospital members of the VHA are located in rural areas throughout Virginia. The complexity of services offered at each hospital also varies. Some hospitals are primary care hospitals while others provide tertiary level care in a number of specialty areas. Some of the acute care hospital members of the VHA have mental health units in their facilities while others combine acute care with long-term rehabilitative care.

The largest acute care hospital member of the VHA is Fairfax Hospital ("Fairfax") located in Falls Church, Virginia, with over 4,600 employees and 656 beds. Equally representative of the membership of the VHA, however, is Bath County Community Hospital, a small rural hospital in Hot Springs, Virginia, with approximately 85 employees and 25 beds. In fact, over twenty-five percent of the VHA's hospital members have less than 100 beds. All acute care hospital members of the VHA will be subject to the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry ("Final Rule" or the "Rule"). 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30 (1989). Thus, all acute care hospital members of the VHA have a vital interest in the American Hospital Association's challenge to the Final Rule promulgated by the NLRB.

The Board's Final Rule provides for eight bargaining units within acute care hospitals. The Rule specifies that the eight units set forth in the Rule are the only appropriate units for bargaining "except in extraordinary circumstances". The eight units deemed appropriate by the Board are: "(1) all registered nurses; (2) all physicians; (3) all professionals except for registered nurses and physicians; (4) all technical employees; (5) all skilled maintenance employees; (6) all business office clerical employees; (7) all guards; and (8) all [other] nonprofessional employees...." 54 Fed. Reg. 16,347-48, 29 C.F.R. § 103.30.

The Rule contains an "extraordinary circumstances" exception which permits the filing of petitions seeking representation of bargaining units which are not in substantial accordance with the provisions of the Rule. *See* Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33,932-33 (1988). The Board's "extraordinary circumstances" exception, however, is extremely narrow. The Board has expressly foreclosed consideration of additional evidence or arguments demonstrating that a particular hospital varies from the norm, even if the variation is "highly unusual". *Id.* at 33,932. Hospitals bear a "heavy burden" to show the existence of extraordinary circumstances rendering application of the Rule inappropriate. *Id.* at 33,933. Specifically, the Board has announced that "increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of 'team' care, and cross-training of employees" would not be considered as a possible extraordinary circumstance. *Id.* at 33,932. Differences in the sizes of various acute care hospitals, the variety of services offered by each institution and differences in staffing patterns among such facilities will also be disregarded as extraordinary circumstances justifying relief from the Rule. *Id.*

One acute care hospital member of the VHA is currently involved in representation proceedings before the Board.[2] On January 17, 1990, the District of Columbia Nurses Association ("DCNA") filed a petition with the NLRB, designated Case No. 5-RC-13331, seeking to represent a unit of approximately 1200 registered nurses at Fairfax Hospital. Action on the union's petition was stayed by the injunction issued in this case by the United States District Court for the Northern District of Illinois. The United States Court of Appeals for the Seventh Circuit reversed the decision of the district court on April 11, 1990, and vacated the district court's injunction against enforcement of the Board's Final Rule. The American Hospital Association obtained a stay of the court of appeals' order, pending this Court's ruling on the petition for a writ of certiorari. The writ of certiorari was granted on October 9, 1990.

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[2] One other hospital, Mary Washington Hospital, won a representation election on November 15, 1990, when employees at the hospital voted against representation by the Laborers' International Union of North America.

If the decision of the Seventh Circuit is upheld, however, it is expected that Region 5 of the NLRB will quickly proceed to apply the Board's Final Rule to the petition for representation of registered nurses at Fairfax Hospital. The Region will certify the proposed unit of registered nurses as an appropriate bargaining unit at Fairfax Hospital without considering whether the special circumstances of employment at the hospital warrant certification of a different bargaining unit, perhaps one which would include all health care professionals at the hospital. If the Seventh Circuit's decision is not reversed, any argument by Fairfax Hospital as to the appropriateness of alternative bargaining units will be foreclosed.

Three of the acute care hospital members of the VHA have employees who are represented by unions. These hospitals have experienced the substantial costs associated with negotiating and administering contracts with union representatives. Those hospitals which have already been organized by unions or which await application of the Board's Final Rule to pending representation petitions have relevant information to bring to bear on the question of the validity of a *per se* bargaining unit rule which would impose as many as eight bargaining units on health care workplaces without affording hospitals an opportunity to be heard on the issue of the appropriateness of such units.

The Board's Final Rule also ignores the differences between acute care hospitals in Virginia, differences which in any particular case make application of the Rule an arbitrary and capricious encroachment on the rights of member hospitals of the VHA to deal with their employees over wages, hours and working conditions. The Rule also ignores significant trends within acute care hospitals in Virginia including the development of mechanisms within hospitals for increasing the coordination and integration of health care delivery to patients. The Board's Final Rule will only lead to increased disruption within Virginia hospitals and an increase in costs for acute care hospitals already struggling to meet budgetary constraints. The Virginia Hospital Association is thus extremely interested in the issues presented by this case and believes it can illuminate the reasons why application of the Board's Final Rule will be harmful to acute care hospital members of the VHA.

II. SUMMARY OF THE ARGUMENT

The issue for resolution in this case is whether the NLRB has acted outside its statutory authority in adopting a rule which conclusively presumes that only eight bargaining units are appropriate for acute care hospitals. The Virginia Hospital Association supports the argument of Petitioner in this case that the Board's Final Rule and its *per se* application to all representation petitions involving acute care hospitals contravenes Section 9(b) of the National Labor Relations Act (the "Act") which requires the Board to determine appropriate bargaining units "in each case". 29 U.S.C. § 159(b). The "in each case" language of Section 9(b) clearly requires adjudication of particular facts in individual cases to determine the appropriate bargaining unit. Therefore, any rule promulgated by the Board which attempts to set uniform standards for bargaining unit determinations must also provide health care employers in particular cases with a meaningful opportunity to demonstrate that there are facts which are peculiar to their facility. If it does not, the rulemaking is invalid as contrary to the language of the Act. It is abundantly clear that the Board's intention in issuing its Final Rule was to preclude individual hospital employers from challenging the Board's determination that only certain bargaining units are appropriate within acute care hospitals. If the Seventh Circuit's decision is not reversed, acute care hospital members of the VHA will be denied a meaningful opportunity to explore the appropriateness of alternative bargaining units in response to future representation petitions.

The Board's Final Rule also ignores the congressional admonition against proliferation which is contained in the legislative history of the Health Care Amendments Act of 1974. Although the Board stated its concern for the admonition against proliferation during the rulemaking proceeding, it is evident that the Final Rule actually promotes proliferation and will substantially increase administrative costs for acute care hospitals in Virginia. The Board has proceeded with rulemaking without concern for the significant costs involved in administering contracts with employee representatives. By disregarding the costs of a rule mandating eight bargaining units within acute care hospitals, the Board ignores the consequences that its prescription for proliferation will visit upon acute care hospitals. In ignoring the

consequences of its action, the Board's claim that it has heeded the congressional admonition against proliferation rings hollow.

Finally, the Board's Final Rule is arbitrary and capricious because it disregards the special circumstances of employment at acute care hospitals in Virginia and threatens to disrupt the delivery of quality health care at those institutions. The arbitrariness of the Board's Rule is underscored by its potential application to all acute care hospitals within Virginia despite the differences in size or complexity of services at each institution. The injustice imposed on acute care hospitals within Virginia by the Board's Final Rule can only be avoided by reversal of the Seventh Circuit's decision and reinstatement of the district court's permanent injunction prohibiting implementation of the Rule.

III. ARGUMENT

When the Board announced in 1987 that it would undertake rulemaking to promulgate a rule of general application to all acute care hospitals in the health care industry, health care employers envisioned rules of general application to representation proceedings which would nevertheless allow individual employers, in any particular case, the opportunity to demonstrate that the unique characteristics of their workplaces required a variation on the standardized bargaining units proposed by the Board. On April 21, 1989, the Board issued its Final Rule establishing eight bargaining units as conclusively appropriate in acute care hospitals. 54 Fed. Reg. 16,336 (1989). Rather than establish rebuttable guidelines for determining bargaining units, the Board crafted a rule which was rigid and inflexible, allowing no meaningful challenge by health care employers to its application in any particular case.

The Petitioner in this case, the American Hospital Association, challenged the Board's Rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court granted a permanent injunction preventing the Board's Final Rule from being implemented. *American Hosp. Ass'n v. NLRB*, 718 F. Supp. 704 (N.D. Ill. 1989). The district court held that the Board's Final Rule failed to heed the congressional admonition against undue proliferation of bargaining units in the health care industry. The court stated:

> A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express concern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

718 F. Supp. at 716.

The United States Court of Appeals for the Seventh Circuit overturned the decision of the district court and vacated the injunction. *American Hosp. Ass'n v. NLRB*, 899 F.2d 651 (7th Cir. 1990). The court of appeals held that the "in each case" requirement of Section 9(b) did not require a case by case determination of bargaining units. The court also held that the congressional admonition against proliferation of units in the health care field did not prohibit implementation of the Rule. Finally, the court of appeals rejected the American Hospital Association's argument that the Rule is arbitrary and capricious because it fails to distinguish between "hospitals of different sizes and missions in different locations". *Id.* at 659.

A. Section 9(b) Of The Act Requires That Health Care Employers Be Afforded A Meaningful Opportunity To Be Heard On The Appropriateness Of Petitioned-For Bargaining Units

For over fifteen years, the Board has used a case by case adjudicatory approach for determining appropriate bargaining units in acute care hospitals. Hospitals facing statutorily imposed obligations with respect to bargaining with unions were afforded the opportunity to create a factual record as to the appropriateness of bargaining units prior to the Board's action on a pending representation petition. The Board's case by case representation procedures quite correctly allow employers to participate in a meaningful manner in discussions relating to important bargaining unit issues. The Virginia Hospital Association contends that the opportunity to be heard is a requisite element of any representation procedure utilized by the Board. Only a rule which allows both parties the opportunity to argue the ap-

propriateness of a proposed unit is consistent with the requirement of Section 9(b) of the Act.

In contrast, the Board's Final Rule denies health care employers confronted with representation petitions the opportunity to argue that only certain bargaining units are appropriate because of the special circumstances of employment at their institutions. The Board has now mandated the appropriateness of certain bargaining units almost without exception. The Board's Final Rule creates a conclusive presumption that precludes participation by one of the interested parties to the representation proceeding, the health care employer. As stated by the Board during its rulemaking proceeding:

> We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers.... Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations....

NPR I, 52 Fed. Reg. 25,142 (1987).

The Board's decision to adopt a conclusive or irrebuttable presumption instead of a rebuttable presumption results in a rule that is inconsistent with the mandate in Section 9(b) to make bargaining unit determinations "in each case." As argued above, that language mandates consideration of specific facts in each case. Unless interested parties are afforded an opportunity to rebut the presumptions created by the Board's Final Rule, the Board's Rule contravenes the Act and thus is invalid. The Board has discretion to promulgate rules only so long as they are consistent with the Act. *See Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 501 (1978); *see also* Note, *NLRB Guidelines for Determining Health Care Industry Bargaining Unit: Judicial Acceptance or Back to the Drawing Board*, 78 Ky. L.J. 143, 158-61 (1989).

Section 9(b) of the National Labor Relations Act provides in pertinent part:

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, plant unit, or subdivision thereof....

29 U.S.C. § 159(b).

In spite of the clear directive in Section 9(b) that the Board determine an appropriate bargaining unit "in each case", the Board proposes to implement a *per se* rule which makes eight bargaining units appropriate in all acute care hospitals regardless of their size or the complexity of their operations. In promulgating the Rule, the Board exceeded its rulemaking authority because it declared a new bargaining unit rule that is in direct conflict with the plain language of the statute. Therefore, the Board's Final Rule must be invalidated.

This Court has consistently held that where the language of an act is plain, it must be enforced according to its terms. *See Caminetti v. United States*, 242 U.S. 470, 485 (1917) ("It is elementary that the meaning of a statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain, ... the sole function of the courts is to enforce it according to its terms."); *see also Consumer Prod. Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980) ("[T]he starting point for interpreting a statute is the language of the statute itself. Absent a clearly expressed legislative intention to the contrary, that language must ordinarily be regarded as conclusive.").

In order to give statutory language its conclusive effect, congressional intent need only be expressed with sufficient precision in the act. *See United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 241 (1989) (finding that the inquiry into the meaning of § 506(b) of the Bankruptcy Code should begin and end with the language of the statute itself); *see also INS v. Cardoza Fonseca*, 480 U.S. 421, 452-53 (1987) (Scalia, J., concurring) ("Judges interpret laws rather than reconstruct legislators' intentions. Where the language of those laws is clear, we are not free to replace it with an unenacted legislative intent."); *Commissioner of Internal Revenue v. Asphalt Prods. Co.*, 482 U.S. 117, 121 (1987) ("Judicial perception that a particular result would be unreasonable may enter into the construction of ambiguous provisions, but cannot justify disregard of what Congress has plainly and intentionally provided.").

In addition, despite the deference generally accorded to agency interpretations of statutes, the Board's discretion and this Court's deference to the agency's interpretation of Section 9(b) of the National Labor Relations Act "is constrained by [this Court's] obligation to honor the clear meaning of a statute, as revealed by its language, purpose and history". *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). The principle of deference to an agency's construction of a statute is not applicable where statutory language is unambiguous. As stated by this Court in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984):

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.

Id. at 842.

The Board's disregard for the "in each case" requirement of Section 9(b), as evidenced by its promulgation of a *per se* rule for determining bargaining units, should be rejected in view of the plain language of the Act and prior conflicting interpretations by the Board concerning its duty under the National Labor Relations Act to determine bargaining units "in each case". Even though the Board now maintains that certain "pre-ordained" bargaining units are *per se* appropriate, the Board, in the past, frequently stated that generalizations as to appropriate bargaining units are not appropriate. *See Otis Hosp., Inc.*, 219 N.L.R.B. 164 (1975) ("[N]ot all health care institutions may be exactly alike.... Between categories of employees similarly titled there may be significant differences, not only in wages, hours, supervision, and the like, but more importantly in functions, responsibilities, procedures, and even expertise."); *Newton-Wellesley Hosp.*, 250 N.L.R.B. 409, 411 (1980) ("in each case" requirement of Section 9(b) held to preclude a *per se* approach to bargaining unit determinations); *St. Francis Hosp.*, 271 N.L.R.B. 948, 953 n.39, 954 (1984) (diverse nature of the health care industry found to preclude

any generalizations as to the appropriateness of particular bargaining units; "No unit is *per se* appropriate and ... separate representation must be justified upon each factual record....").

This Court has declined to defer to an agency's decision where the agency's position is inconsistent with earlier interpretations. *See INS v. Cardoza Fonseca*, 480 U.S. at 446 n.30 ("An agency's interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."). The NLRB has construed "in each case" language in another statute, the Postal Reorganization Act, as requiring case by case determinations of bargaining units. In *United States Postal Serv.*, 208 N.L.R.B. 948, 952-53 (1974), the Board followed its traditional community of interests analysis in considering the appropriateness of certain bargaining units involving the Postal Service. Language in the Postal Reorganization Act persuaded the Board to analyze the petitions on a case by case basis. That language reads: "The National Labor Relations Board shall decide in each case the unit appropriate for collective bargaining in the Postal Service...." 39 U.S.C. § 1202. No justification exists for departing from a case by case analysis of health care industry petitions where identical language in Section 9(b) also mandates bargaining unit determinations on a case by case basis.

Application of the Rule will prevent hospitals from arguing the appropriateness of alternative bargaining units in response to petitions pending before the NLRB. The variables that make each hospital unique will go unnoticed if the Board's new Rule is allowed to be implemented. For instance, the petition for an all RN unit at Fairfax Hospital will undoubtedly be approved without a specific analysis of employment conditions at Fairfax. If the union is successful in convincing registered nurses at Fairfax Hospital to vote for representation, the hospital will be confronted with the dilemma of having to negotiate a collective bargaining agreement which will govern the working conditions of only a portion of the integrated team of health care professionals providing patient care services at Fairfax. Such a situation will result in a segregated workforce with some professionals working under work rules governed by the collective bargaining agreement and others working under the policies of Fairfax Hospital.

There are undoubtedly many factors which militate in favor of a broader all professional unit at Fairfax Hospital. Those factors will never come to light if the Board's Rule is applied to the pending petition. A similar unhappy ending will be repeated each time another Virginia hospital is confronted with a representation petition. The Board's narrow "extraordinary circumstances" exception will not allow any health care employer to demonstrate that a community of interests exists in its workplace which is broader than that which is implicit in the bargaining units proposed in the Final Rule. Thus, a hospital which wishes to demonstrate that its technical employees often interact with, or perform duties consistent with the functions of, its nonprofessional employees (i.e., licensed practical nurses performing clerical tasks, assisting or performing housekeeping functions as the need arises, or coordinating meal selection and distribution of menus for patients) will be prevented from demonstrating the integrated nature of its nonprofessional workforce.

The immediate harm that will result to acute care hospitals as a consequence of the Board's decision to abandon case by case adjudication and resort to a *per se* rule regarding bargaining units is obvious in the case of hospitals such as Fairfax Hospital. The hospital is an interested party to its representation proceeding before the Board yet the Board's Rule will effectively prohibit it from presenting any evidence which might demonstrate that the Board's mandated bargaining unit is not appropriate. In the case of Fairfax Hospital, the Rule will have an immediate impact. It can be seen, however, that the proliferation of bargaining units which will be fueled by the new Rule and the resulting increase in administrative costs at other hospitals within Virginia also make the Final Rule unjustifiable.

B. The Board's Rule Ignores The Congressional Admonition Against Undue Proliferation Of Bargaining Units In The Health Care Industry

A crucial issue to be determined in this case is the weight that should be accorded to the congressional admonition in the legislative history of the Health Care Amendments Act of 1974 that "due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry". S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess.

6-7 (1974). The district court in this case found the congressional admonition to be a specific directive to the Board on the manner in which to proceed when determining bargaining units in the health care field. The court said:

> [C]ongress drew attention to health care by adding another concern, which *must be addressed by the Board in certifying bargaining units in that industry*. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, *it must use the means least likely to cause unit proliferation to achieve their objective.*

718 F. Supp. at 712 (emphasis added).

The district court found that the Board, in promulgating its new rule, "failed to give more than mere lip service mention of the Congressional admonition". *Id.* at 714. The court concluded that the Final Rule, because it designated an "absolute number of appropriate units" and mandated a "particular division of the workforce", was "not responsive to Congress' express concern". *Id.* at 716.

In contrast, the Seventh Circuit held that the Board's determination that eight bargaining units were *per se* appropriate in acute care hospitals was "entitled to broad judicial deference". 899 F.2d at 656. The court of appeals said:

> It is not for us to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions that it does, or slightly fewer.

Id. at 657.

The court of appeals found that the congressional admonition was entitled only to "respectful consideration" and construed Congress' intent as "cautionary rather than directive." *Id.* at 658. The court's decision in this respect is contrary to decisions of other courts of appeals which have given controlling weight to the congressional admonition against undue proliferation. *See, e.g., Trustees of the Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 676, 632 (2d Cir. 1983) (referring to the admonition, the court said: "[T]his legislative commitment to nonproliferation, explicit in the legislative history,

binds the NLRB in its determination of the appropriate collective bargaining unit in a health care institution."); *NLRB v. HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982) (legislative commitment to nonproliferation is "binding on the NLRB" and requires the Board to "develop a reasoned, non-conclusory method of implementing the statutory intent by articulation of specific criteria"); *St. Anthony Hosp. Sys., Inc. v. NLRB*, 884 F.2d 518, 519-20 and n.3 (10th Cir. 1989) (concluding that the congressional admonition requires that "traditional factors used in ... [bargaining unit] determinations must be put in balance against the public interest in preventing fragmentation in the health care field").

In *NLRB v. Frederick Memorial Hosp.*, 691 F.2d 191 (4th Cir. 1982), the Fourth Circuit held that the NLRB must explain how each determination of a bargaining unit implements the congressional admonition against proliferation. The NLRB had sought enforcement of an order finding a unit composed of registered nurses to be appropriate at Frederick Memorial Hospital. The court of appeals rejected the Board's decision approving the all RN unit because the NLRB failed to give due consideration to the issue of proliferation of bargaining units at the hospital. 691 F.2d at 194.

The underlying decision of the Board, *Frederick Memorial Hosp., Inc.*, 254 N.L.R.B. 36 (1981), had upheld the Regional Director's determination that the registered nurses at Frederick Memorial Hospital possessed a sufficient community of interests, separate and apart from all other professionals, to justify their own unit for bargaining purposes. The Board made a detailed analysis of the working conditions of registered nurses and other allied health professionals at the hospital before concluding that the RN unit was appropriate. The court of appeals approved the detailed analysis undertaken by the Board in the underlying case. The court refused to enforce the decision, however, because neither the Regional Director nor the Board addressed the question of proliferation when considering the appropriateness of the RN unit. The court said:

> The Board may not depend solely on the traditional community of interests test when making a unit determination for health care institution employees. As other courts have held, the Board must give due consideration to the congressional admonition against proliferation. Furthermore, a Board decision must clearly explain "the manner in which its unit determination ... implement[s] or reflect[s] that admonition . . . ."
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> . . .
>
> A reviewing court, no less than the Board, is bound to give effect to the congressional admonition against proliferation. The court cannot in the first instance adjudicate whether certification of a unit is consistent with congressional intent. Nor can the court adequately review the Board's decision and order unless the Board clearly discloses why certification of the unit comports with the necessity of preventing proliferation.

691 F.2d at 194 (citations omitted).

The Board did not give due consideration to preventing proliferation of bargaining units when it framed its Final Rule. Despite the Board's pronouncement in its Second Notice of Proposed Rulemaking that it had "carefully considered the Congressional admonition against proliferation", 53 Fed. Reg. 33,933, the Board did not clearly explain how its Final Rule implements Congress' concern for preventing proliferation. The Board attempts to justify its selection of eight units as appropriate for bargaining by arguing that the increase from two broad units for bargaining (the Board's *St. Francis II* standard) to eight units is not "proliferation", as that term is commonly understood (i.e., to cause to grow or increase rapidly), but rather is only an increase which reflects employee groups which have "separate labor markets". *Id.* at 33,933. Finally, by creating a definitional framework which serves only its own administrative goals, the Board was able to buttress its conclusion that the Final Rule will not result in proliferation by defining proliferation broadly during rulemaking to be the creation of "fifteen to twenty-plus units". *Id.*

The arbitrary selection of fifteen units as the point where proliferation starts does considerable injury to the congressional admonition and ignores the costs and disruption that can occur as a consequence of even one additional unit for bargaining. Even one organized unit can result in substantial administrative costs because

the provisions in a union agreement must be administered separately from personnel policies applicable to nonunion employees. Eligibility for leave may be different for union and nonunion employees. Differences between hospital employee benefit plans and union benefit plans may substantially impact administrative costs. The union's grievance and arbitration procedure is usually quite different from the hospital's grievance procedure. Finally, administering payroll is extremely troublesome for hospital administrators when union and nonunion employees make up the same workforce. These administrative costs will be doubled, tripled, or, in the worst case scenario, octupled by the operation of the Board's Final Rule.

Hospitals already administering two or more contracts with union representatives have found that, although there may be common provisions in each contract, the more substantial administrative costs are not reduced by having similar provisions in several agreements. For example, one of the most costly and time consuming contract administration problems is dealing with grievances from the union concerning alleged violations of the agreement. Because grievances are generally brought on behalf of an individual union member and are quite fact specific, a hospital administrator's task is not made less costly simply because the administrator may have processed a similar grievance from another employee represented by a separate union. Similarly, any grievance that goes to arbitration will have costs that are repeated each time a new grievance is not resolved prior to arbitration. Arbitration also normally involves outside counsel and therefore the costs for such proceedings accelerate rapidly because of attorneys' fees. Thus, one of the most expensive administrative functions relating to contracts with unions is a cost that is repeated over and over again regardless of the administrator's experience with other union agreements.

Even where hospitals have agreements with one union representing different bargaining units within the hospital, the administrative costs are not substantially reduced because of the fact of duplicate representation. This is especially true in the case of negotiating costs. Unions are loathe to negotiate contracts which terminate at the same point in time each year. Unions have increased bargaining leverage by utilizing separate expiration dates for different bargaining units within the hospital. Through the use of recurring § 8(g) notices and

the threat of bargaining unit walkouts by different groups of employees, the union can successfully pressure the hospital administration to accede to its bargaining demands. No self-respecting union will give up collective bargaining leverage and, thus, there are generally no savings realized during negotiations from having the same union represent different groups of employees.

Virginia hospitals are experiencing the same financial difficulties confronting hospitals throughout the nation. Between 1984 and 1987, forty-one member hospitals of the Virginia Hospital Association experienced a negative operating margin. This means that even though the hospitals may have seen an increase in net revenues, their expenses rose quicker than revenues, thus resulting in negative operating margins. More recently, twenty-seven acute care hospital members experienced operating losses in 1989. The majority of these hospitals were located in rural areas.

Utilization statistics of member institutions of the Virginia Hospital Association show that eighty-two hospitals had a decline in occupancy rates during the period 1984-1987, with sixty-five hospitals experiencing a decrease in admissions as well. Occupancy levels for hospitals with operating losses continued to decline in 1988 and 1989. At present, many small hospitals in Virginia are only operating at approximately fifty percent occupancy. In many cases, large urban hospitals are faring no better.

The VHA has three member hospitals with employees represented by unions. These hospitals have experienced the costs and disruption which accompany organized bargaining units within health care work forces. For example, Wise Appalachian Regional Hospital in Wise, Virginia, was hit with a ninety-one day work stoppage in 1986 by the United Steelworkers. The Steelworkers represent registered nurses, other allied health professionals, and nonprofessionals at the hospital. The strike caused disruption in hospital operations and substantial financial losses to the hospital.

Norton Community Hospital ("Norton") in Norton, Virginia, is a relatively small acute care hospital with only 129 beds and approximately 300 employees. The United Steelworkers, Local 14459, represents two bargaining units at Norton: a nonprofessional unit comprised of licensed practical nurses, nurses' assistants, dieticians,

business office staff, and service and maintenance employees; and a professional unit which includes registered nurses and microbiologists. The cost of negotiating with Local 14459 substantially increases Norton's overall operational costs. Although the same union represents both of Norton's bargaining units, the contracts are negotiated separately and terminate at different times. Even though Norton's relationship with the Steelworkers spans approximately 30 years, negotiations often require at least 15 sessions with each session lasting an average of six hours.

Preliminary preparations for the negotiation of either of Norton's contracts are also very time consuming and labor intense. The management negotiating team, which is comprised of four members from upper level management, meets with the managers of the hospital's departments and with the executive management staff to review difficulties arising in the administration of the current contract and solicits comments on provisions which may need to be included in the new agreement. The total time involved in such preparation is estimated to be approximately 240 hours. This estimate does not include clerical time involved in typing draft proposals or counter proposals.

In July 1990, employees at Dickenson County Medical Center ("Dickenson") in Clintwood, Virginia, voted for representation by the United Mine Workers of America ("UMWA"). Dickenson is a small hospital with only 50 beds employing 120 individuals, 100 of whom will now be represented by the union. The UMWA represents two units, a broad nonprofessional unit and a professional unit representing the registered nurses. It is anticipated that considerable time and resources will be expended to reach a contract agreement. Negotiations began with the UMWA following certification of the election results. The negotiations have been ongoing since that time and there have been a number of bargaining sessions between the hospital's negotiating team, which includes outside counsel, and the UMWA. At this time, a number of issues remain to be resolved.

In one sense, it is fortunate for Dickenson that its employees were organized prior to implementation of the Board's Final Rule. Under the Board's new Rule, the employees currently represented by the

UMWA might have been separated into six separate bargaining units.[3] Such a fragmentation of the workforce would produce a serious disruption in the daily administration and operation of such a small hospital.

The Board's Final Rule with its provision for eight different bargaining units is potentially an administrative nightmare for all acute care hospitals. The effect of this Rule will not be limited to hospitals with pending representation petitions. Unions have uniformly expressed their renewed interest in organizing hospitals along the lines set forth in the Board's Rule. They have positioned themselves to take immediate advantage of the Rule's prescription for proliferation. The National Union of Hospital and Health Care Employees recently announced that it would triple its 28,000 member dues in order to finance a massive, nationwide organizing campaign in 1991. The union expects this Court to approve the Board's Final Rule and, in response, has decided that it will add 400 more organizers to undertake what the union calls "the largest mobilization for organizing ever undertaken by the American labor movement." 213 Daily Labor Report (BNA) at p. A-18 (11-2-90). The United Mine Workers' representative who organized Dickenson County Medical Center has bragged that his union would attempt to "organize everything we can here in Southwest Virginia." The Coalfield Progress, July 24, 1990, at 1, col. 1. Thus, hospitals can expect an immediate and substantial increase in union organizing activity among the separate employee groups which correspond to the eight bargaining units in the Final Rule.

C. The Board's Rule Is Arbitrary And Capricious Because It Applies To All Hospitals In Virginia Regardless Of Their Size And The Diversity Of Services Offered At Each Facility

The Board brushed aside the differences among acute care hospitals during its rulemaking proceeding by describing the differences in size and the variety of services offered as being merely "minor

[3] The Board's Final Rule does allow for stipulated bargaining units which are not in accordance with the units specified in the Rule. 29 CFR § 103.30 (d). As a practical matter, however, no union will stipulate to a broader unit than that petitioned-for unless the union is confident of victory in a representation election involving the greater number of employees in the broader unit.

differences". *See* NPR II, 53 Fed. Reg. 33,932. Such a superficial assessment of modern health care institutions illustrates the Board's lack of insight into the actual operation and administration of different types of hospitals as well as its disregard for the specific needs which certain hospitals fulfill in a particular community. It is absurd to characterize the differences between large metropolitan hospitals, which have a complex, multi-facility operation and a variety of specialized service departments, and small rural hospitals, where administrators and employees alike fulfill several different job functions, as "minor". It is precisely the size of a hospital and the work being done within that hospital which helps create the community of interests shared by employees at any particular facility. The Board's decision to apply the Rule to all acute care hospitals regardless of size and the variety of services offered at each institution is arbitrary and capricious because it ignores two substantial factors contributing to the growth of common interests.

Member hospitals within the VHA vary from large metropolitan hospitals like Fairfax Hospital with 656 beds and over 4,600 employees to small rural hospitals like Bath County Community Hospital ("Bath County"), which has 25 beds and 85 employees. Fairfax Hospital has over 1,436 registered nurses in comparison to the 20 registered nurses employed at Bath County. Similarly, Richmond Memorial Hospital ("Richmond Memorial") in Richmond, Virginia, has 420 beds and 292 registered nurses, while St. Mary's Hospital ("St. Mary's") in Norton, Virginia, has 54 beds and 8 registered nurses.

The VHA is especially concerned about the potential harm that will be visited on small hospitals within the state if the Board's Rule is allowed to be implemented. Sixty percent of the acute care hospitals in Virginia are small hospitals with less than 200 beds. Twenty-five percent of the VHA's acute care hospital members have less than 100 beds. These hospitals are most vulnerable to the increase in costs that will be incurred as a result of the Board's Final Rule. Of hospitals with less than 100 beds in Virginia, forty-eight percent suffered operating losses in either 1988 or 1989. A small hospital simply cannot absorb the costs of having to negotiate and administer eight different contracts. Even one or two bargaining units may jeopardize

the welfare of small rural hospitals.[4] For example, on the day the union claimed victory at Dickenson County Medical Center, only 12 of the hospital's 50 beds were occupied. The hospital's administrator believes that the cost of dealing with the union will bring additional financial hardship on an institution already struggling to survive. The Coalfield Progress, July 24, 1990, at 1, col. 3.

Size alone is not the only factor which must be considered in evaluating the community of interests likely to be present in a hospital workforce. The variety of medical services available in Virginia hospitals provides varied employment opportunities and experiences for health care professionals. Metropolitan hospitals like Fairfax Hospital, Roanoke Memorial Hospitals, and The Alexandria Hospital have a variety of specialized departments providing sophisticated care to patients with severe injuries and illnesses. Health care professionals working in these specialty departments may have more in common with each other than with similarly licensed professionals elsewhere in the hospital. The specialized nature of care in these departments requires greater integration in responding to patients' medical needs. For example, registered nurses assigned to the pediatric intensive care unit or the neonatal intensive care unit at Fairfax Hospital must work closely with social workers, physical therapists, occupational therapists, speech pathologists, and respiratory therapists in providing comprehensive treatment in these specialized areas. The high degree of specialization and intricacy of medical/surgical procedures used in the delivery of these services create an employment atmosphere conducive to the growth of a community of interests among the registered nurses and allied health professionals in these departments.

The Alexandria Hospital has a special cancer center in which registered nurses provide clinical expertise to patients undergoing various forms of cancer treatment. The center's staff includes a dosimetrist, a senior dosimetrist, radiation therapists, a simulation technician, registered nurses and social workers. All these employees not only work together and share similar working conditions but continuously confer with each other to ensure that treatment is effective. As a result, registered nurses in the cancer center are likely to

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[4] Perhaps not unexpectedly, all three unionized hospitals in Virginia experienced operating losses in either 1988 or 1989.

have more in common with other allied health professionals in the center than with registered nurses in other departments of the hospital.

Roanoke Memorial Hospitals ("Roanoke") has several specialty units which require registered nurses and allied health professionals to coordinate their services in providing patient care. Diabetic services at Roanoke utilizes registered nurses, licensed practical nurses, nurses' assistants, dieticians, social workers, physical therapists, occupational therapists, and medical technologists, in addressing the medical, social, and psychological needs of diabetic patients. Roanoke's neonatal care unit is staffed by registered nurses, licensed practical nurses, respiratory therapists, x-ray technicians, medical technologists and social workers.

There are many more examples of specialty units within Virginia hospitals where various health care professionals must coordinate their services to provide efficient and effective health care treatment. These examples undermine the basic assumption implicit in the Board's Final Rule, i.e., that all registered nurses working in a complex and multidisciplinary metropolitan hospital share similar interests and working conditions with other registered nurses throughout the facility and do not share common interests with other allied health professionals in the hospital.

On the other hand, smaller hospitals in Virginia also have unique characteristics which make the Board's *per se* rule arbitrary and capricious. For example, smaller facilities like Bath County Community Hospital and St. Mary's Hospital focus their efforts on providing quality primary care and general surgery services to the local community. These smaller rural hospitals do not have the resources to staff and equip sophisticated tertiary care units, but, instead, concentrate on stabilizing a severely injured patient until transfer to a more advanced unit is arranged. Because of this emphasis on primary care, these facilities do not have the diverse specialization among job functions found in the larger metropolitan facilities. Thus, registered nurses in these hospitals may, in fact, share similar duties. Equally true, however, is the fact that registered nurses in these smaller facilities also share duties with other employees or may, as part of their routine job responsibilities, be engaged in procedures for which larger hospitals employ special technical employees. For example, Culpeper

Memorial Hospital in Culpeper, Virginia employs phlebotomists and respiratory therapists but based on budgetary constraints and actual demand, these employees may not be scheduled for certain shifts. During these shifts, the registered nurse draws blood for any necessary laboratory samples and will adjust or apply ventilators for respiratory-dependent patients.

In addition, the division of functions between professionals, technicals and nonprofessionals in smaller hospitals often becomes blurred. For example, in Lonesome Pine Hospital, a 60-bed acute care hospital located in Big Stone Gap, Virginia, registered nurses act as unit secretaries; material management employees are involved in the clerical aspects of their position; and a licensed practical nurse in physical therapy does all the charting and typing of reports and forms.

The cooperation and interaction among staff in smaller hospitals extends throughout the hospitals. The focus in these facilities is on the common goal of providing competent health care. Therefore, registered nurses will assist office workers in completing administrative reports; office workers will help clean patient care units if the need arises; and housekeepers will stop cleaning, wash their hands, and fluff a patient's pillow. At Lonesome Pine, a registered nurse may have to clean rooms during the midnight shift as the need arises because no housekeeper is scheduled for that shift. The pharmacist at Lonesome Pine also supervises the material management staff as part of his duties. Pharmacy technicals are cross-trained in material management, and the material management staff may substitute as pharmacy technicals. This type of interaction among employees at small hospitals illustrates that the Final Rule is arbitrary and capricious in not recognizing that such special conditions may exist which make the Rule's mandated units inappropriate. Because the Rule's narrow extraordinary circumstances exception will not allow small hospitals to demonstrate the uniqueness of their facilities, the ability of these rural hospitals to operate efficiently and economically will be diminished.

D. The Board's Rule Is Arbitrary And Capricious Because It Ignores The Integration And Interaction Of Health Care Employees Within Virginia Hospitals

The health care industry is changing dramatically in Virginia and the Board's Rule provides no avenue for recognition of these changes. For example, the increasing use of outpatient clinics in providing both preventative medical services and minor surgery has contributed to the declining occupancy rates experienced by acute care hospitals. A natural outgrowth of this trend is that patients now admitted are more acutely and seriously ill than in the past. This obligates hospitals to restructure traditional methods of patient care to meet the more specific needs of their patients.

Many Virginia hospitals have responded to these changes by redesigning their approach to patient care in a manner which increases the integration of professionals and nonprofessionals in the workplace. Many hospitals have created specific mechanisms for increasing the coordination between care givers at their facilities. For example, many hospitals have begun utilizing interdisciplinary committees to resolve difficult medical problems relating to individual patients or simply to enhance patient care generally by planning for coordinated delivery of medical services to patients. These committees, which may be designated "patient care planning committees", "collaborative committees for patient care", or "interdisciplinary committees on patient care", provide a comprehensive approach to the medical, physical, emotional and psychological needs of a patient. The more complex patient care questions may be discussed during formalized "rounds" where an interdisciplinary group of professionals will discuss the more challenging patients under their care.

For example, The Alexandria Hospital utilizes an integrated patient care system. All service units hold meetings to coordinate patient care. Meetings are held weekly or more frequently depending on the need of the patients, and the attendees include dieticians, social workers, registered nurses, physicians and rehabilitation therapists assigned to a particular case. These meetings promote an exchange of information to enable the professional team to assess a patient's

present condition, reevaluate and alter treatment, or prepare the patient for discharge.

The increasing tendency of modern hospitals is to structure their organizations in a manner which promotes the integration of individual professionals and which better coordinates direct patient care services with support services. For example, hospitals are eliminating separate nursing divisions, and, instead, structuring hospital departments along service lines. National Hospital for Orthopaedics and Rehabilitation, located in Arlington, Virginia, has restructured its organization by joining nursing and ancillary services in a unified department known as Patient Care Services, managed by the Vice President, Patient Care Services. This structure improves the quality of patient care because one person is aware of difficulties encountered in all aspects of direct patient care and can move quickly should any problems arise. Additionally, the hospital can better assure that all aspects of its medical services reflect management's goal of a collaborative, integrated approach to patient care.

In light of such organizational changes, the Board's decision to segregate registered nurses in a separate bargaining unit is especially arbitrary and capricious. It is not uncommon for registered nurses to be working in laboratories with medical technologists, in cardiovascular services departments along side cardiovascular technologists, in "rehabilitation" units with physical therapists and occupational therapists, in "psych" units with mental health counselors and social workers, in radiology departments with x-ray technicians, or in utilization review departments where they interact with many different health care professionals.

There are other multidisciplinary committees being used in Virginia hospitals to fulfill various patient care and hospital operating goals, both routinely and on an *ad hoc* basis. For example, Franklin Memorial Hospital in Rocky Mount, Virginia, utilizes a multidisciplinary committee consisting of medical technologists, radiologic technologists, nurses, and a pharmacist to investigate improvements in the delivery of patient care and to develop a plan for implementation of proposed changes. Radford Community Hospital in Radford, Virginia, uses a "team treatment committee" in evaluating and determining the treatment modality for hospital patients requiring respiratory

treatment. This team, composed of a registered nurse, the attending physician and the respiratory therapist, performs joint reviews of patient care. The patient care evaluation committee at Gill Memorial Eye, Ear, Nose & Throat Hospital in Roanoke, Virginia, is responsible for reviewing all issues concerning patient care and the results of this meeting are reported to physicians for their monthly medical staff meetings. The committee is multidisciplinary with representatives of all departments serving on the committee.

A multidisciplinary committee, known as the professional advisory committee, is used in Giles Memorial Hospital in Pearisburg, Virginia to review the performance and conduct of its home health department. This department provides skilled nursing services and other personal care services in a patient's home. The professional advisory committee is composed of physicians, nursing representatives and physical therapists. Acute care hospitals which incorporate long-term or extended care within their facilities also use a multidisciplinary committee to develop and evaluate long-term patient care. For example, at Wythe County Community Hospital, in Wytheville, Virginia, a treatment planning committee meets regularly to discuss its long-term patients. The committee is comprised of physicians, nurses, social workers, discharge planners, dieticians and rehabilitation therapists. Psychiatric units in acute care hospitals also integrate professionals to enhance services. At St. Mary's Hospital, the patient care treatment team includes members of social services, quality assurance, utilization review, psychiatry and the recreational activities director. Under the supervision of the psychiatrist, this group meets one or two days a week and develops a complete plan of treatment, including outpatient care.

Not only is there increased integration among the different disciplines providing health care services as a result of collaborative concepts for patient care, but the very nature of modern health care requires heightened interaction between professionals. No longer is treatment provided only through the efforts of the attending physician and a nurse. During a patient's stay, he or she will be visited by therapists, technologists, and other technicals who provide treatment, run tests, operate sophisticated equipment, and ensure the equipment being used is performing properly. In addition, there is an increasing awareness that a patient's mental attitude regarding an illness is an

important component of recovery. Therefore, social workers and mental health counselors will talk with patients during and after their stay at a hospital.

Nutritional support is another key area where professionals frequently collaborate concerning the nutritional requirements of patients. Many hospitals are establishing formal nutritional support teams which combine the expertise of registered nurses, physicians, dieticians, and pharmacists to utilize nutritional support for enhancing and accelerating a patient's recovery.

Discharge planning has become a very common team concept for modern acute care hospitals. Discharge planning can take many variations. For example, Franklin Memorial's Hospital's discharge planning team is composed of nurses and social workers who meet three times a week to assess the needs of patients after discharge. St. Mary's Hospital's discharge planning department includes a social worker, a utilization review/quality assurance coordinator, the education director, home health services employees and registered nurses. Culpeper Memorial Hospital assigns a registered nurse to the discharge planning department who works with social workers to assist patients. In Bedford County Memorial Hospital in Bedford, Virginia, a social worker is responsible for developing the discharge plan but confers with attending physicians and registered nurses before finalizing the plan. Despite the varied procedural methods adopted by hospitals for discharge planning, all procedures usually require interaction among many different health care professionals, including registered nurses, social workers, rehabilitation therapists, pharmacists and physicians.

Other departments within acute care hospitals demonstrate the frequent interaction of health care professionals in modern facilities. Operating rooms and emergency rooms are common examples of departments where various specialists coordinate and combine their expertise to provide patient care. The Bedford County Memorial Hospital surgery room is a good example of coordinated medical services in a small facility. Nurses, medical technologists, medical lab technicians, respiratory therapists, radiologic technologists and anesthetists work together to treat emergency room patients at Bedford County. Nurses will get IVs started, change dressings and help the

physicians with suturing, while medical technologists and medical lab technicians come to the emergency room to run lab tests or draw blood. If the patient has respiratory distress, the respiratory therapist will put the patient on a respirator. In addition, x-ray personnel use mobile, portable equipment to take x-rays of patients. Similarly, at Stonewall Jackson Hospital's emergency room, registered nurses administer medication to patients and assist physicians while medical laboratory technicians draw blood and analyze specimens, respiratory therapists ventilate patients who have cardiac arrest and radiology technologists confirm the placement of ventilation tubes. These coordinated systems for delivering emergency care are repeated throughout other Virginia hospitals.

Operating rooms have always been a model for teamwork within hospitals. All hospitals maximize the coordination of professionals and technical personnel during surgery to achieve efficient yet careful surgical procedures. For example, Mount Vernon Hospital in Alexandria, Virginia, utilizes a "surgical suite" to achieve an interdisciplinary approach to surgery with registerd nurses, surgical technicians, physicians, and physicians' assistants working together to deliver quality health care.

The integration and interaction of health care professionals in modern acute care hospitals are very important factors that should be explored by the Board before using an arbitrary bargaining unit to separate registered nurses from other health care professionals in an otherwise integrated workplace. A case by case adjudication of appropriate bargaining units would reveal that health care professionals in Virginia hospitals participate in common benefit plans and work under uniform personnel policies. They have comparable salaries, receive identical bonus pay, work similar schedules, and receive identical shift differential. Interdisciplinary training is accomplished through other collaborative practice groups. Health care professionals may give in-service training to each other in their respective specialties. Interaction of employees is stimulated further by training or educational sessions on more generic subjects such as infection control, CPR training, stress management, hazard abatement, or EAP opportunities.

This team approach to patient care that is prevalent throughout many Virginia hospitals will clearly be disrupted by the *per se* application of the Board's Final Rule. The Final Rule forces professionals working on the same hospital team into separate units for bargaining. The Rule also increases the likelihood that these professionals will be represented by different unions. Conflicting work rules regarding hours of work, overtime and other working conditions are likely to destroy the cohesion fostered by each hospital's integrated approach to patient care. Ultimately, patient care may be impaired by conflict between union members, thereby creating the very situation which Congress attempted to avert in drafting the Health Care Amendments Act and instructing the NLRB to avoid proliferation.

IV. CONCLUSION

For all the foregoing reasons, and for the reasons stated in the brief of the America Hospital Association, the decision of the Seventh Circuit should be reversed.

Respectfully submitted,

By:_____

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APPENDIX

U.S. Department of Justice
Office of the Solicitor General

October 24, 1990

John G. Kruchko
Kruchko & Fries
Counselors at Law
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*
No. 90-97

Dear Mr. Kruchko:

In response to your letter of October 23, 1990 I hereby consent to the filing in the above-captioned case of an *amicus curiae* brief on behalf of the Virginia Hospital Association.

Sincerely,

/s/ Kenneth W. Starr

Solicitor General

DICKSTEIN, SHAPIRO & MORIN

October 24, 1990

John G. Kruchko, Esquire
Kruchko & Fries
7929 Westpark Drive
Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. N.L.R.B.*, et al.
No. 90-97

Dear Mr. Kruchko:

The American Nurses' Association consents to your filing of an *amicus curiae* brief in the above-referenced matter on behalf of the Virginia Hospital Association.

Sincerely,

/s/ Woody N. Peterson

WNP: hmp

MAYER, BROWN & PLATT

October 17, 1990

Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Re: *American Hospital Association v. NLRB*

Dear Mr. Lusky:

On behalf of the American Hospital Association, I hereby consent to the filing of a brief *amicus curiae* by the Fairfax Hospital System, et al. in the above-referenced case.

Sincerely,

/s/ James D. Holzhauer

JDH: cml

**AMERICAN FEDERATION
OF LABOR AND CONGRESS
OF INDUSTRIAL ORGANIZATIONS**

Ocotber 29, 1990

Mr. John G. Kruchko
Mr. Paul M. Lusky, Esq.
Kruchko & Fries
7929 Westpark Drive, Suite 202
McLean, Virginia 22102

Dear Messrs. Kruchko & Lusky:

Re: *American Hospital Association v. N.L.R.B., et al.* (Supreme Court No. 90-97)

The American Federation of Labor and Congress of Industrial Organizations hereby consents to the timely filing of an amicus curiae brief in support of the petitioner in the above-referenced matter on behalf of the Maryland and Virginia Hospital Associations.

Sincerely yours,

/s/ David M. Silberman

Associate General Counsel